COMPANY _____

Magnuson, McHugh & Company, P.A.
CPAs and Consultants

REQUEST FOR REIMBURSEMENT FORM

Employee Name: _____

Employee SSN: ### - _____ - _____

Daytime Contact Phone or Email: _____

Directions to complete this Request Form –

Complete all boxes – incomplete forms may delay reimbursement.
Attached receipts must include:

- Date of Service (not date of payment)
- Provider's Name
- Amount charged

Enter the total amount requested in the Claim Total box
Attach copies of receipts – Cancelled checks or credit card receipts do not qualify per IRS Code.
Allow 5 business days for processing after we receive your claim.

To the best of my knowledge and belief, my statements in this Reimbursement Request Form are complete and true. I certify that my family member or I have received the services described below on the dates indicated. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been and will not be reimbursed by any benefit plan or insurance company or claimed as an income tax deduction. I authorize my Flexible Spending Account be reduced by the amounts requested. **All claims will be processed in the order received.**

MINIMUM CHECK AMOUNT $10.00

Signature: _____ **Date:** _____

COMPLETE ALL APPROPRIATE BOXES – INCOMPLETE FORMS MAY BE DELAYED

DEBIT CARD	FSA	HRA	DCAP	INS PREMIUMS	DATE OF SERVICE (not date of payment)	TYPE OF SERVICE	AMOUNT REQUESTED

REFERENCE GUIDE: Please ***X*** the corresponding box above

DEBIT CARD – substantiation receipts attached	
FSA – unreimbursed medical expenses	**HRA–Employer Funded Medical Expense Reimbursement**
DCAP – Dependent Care/Child Daycare	**INS PREMIUMS–Individual Medical Insurance Policy**

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Count On Us To Care